# VIRGINIA MEDICAID REQUEST FOR DRUG PRIOR AUTHORIZATION

**COMMONWEALTH of VIRGINIA**
*Department of Medical Assistance Services*

Requests for prior authorization (PA) must include patient name, Medicaid ID#, and drug name. Appropriate clinical information to support the request on the basis of medical necessity must be submitted. **SUBMISSION OF DOCUMENTATION DOES NOT GUARANTEE COVERAGE BY THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES AND FINAL COVERAGE DECISIONS MAY BE AFFECTED BY SPECIFIC MEDICAID LIMITATIONS.**
**THIS FORM SHOULD NOT BE USED FOR PA REQUESTS FOR WEIGHT LOSS DRUGS**

The completed form may be **FAXED TO 800-932-6651.** Requests may be phoned to 800-932-6648.

**Requests may be mailed to:** First Health Services Corporation / 4300 Cox Road / Glen Allen, VA 23060 / ATTN: MAP

## PATIENT INFORMATION

| | |
|---|---|
| Patient's Name: | Patient's Diagnosis: |
| Patient's Medicaid ID#: (12 digits) | |
| Patient's Date of Birth: | |

## DRUG INFORMATION

| | |
|---|---|
| Drug Name, Dosage Form & Strength: | Quantity Per Day: |

Has patient had previous pharmaceutical therapy for the above diagnosis? ☐ Yes ☐ No

Does the patient reside in a Long Term Care facility? ☐ Yes ☐ No

List pharmaceutical agents attempted and outcome:

1.

2.

3.

**Medical necessity**: Provide clinical evidence that the preferred agent(s) will not provide adequate benefit:

## PHYSICIAN INFORMATION

| | |
|---|---|
| Physician's Name (print): | Today's Date: |
| Physician's Signature: | Authorization begin date: |
| Physician's DEA#: | Phone #: ( ) |
| Physician's Medicaid Provider ID#: | Fax #: ( ) |

**PLEASE INCLUDE ALL REQUESTED INFORMATION**
**INCOMPLETE FORMS WILL DELAY THE PRIOR AUTHORIZATION PROCESS**

**FAX TO 800-932-6651**

**PRIOR AUTHORIZATION CRITERIA IS SUBJECT TO CHANGE AND THUS DRUG COVERAGE**

**PDL and Weight Loss PA forms are available at**
**http://www.dmas.virginia.gov/pharm-home.htm or http://virginia.fhsc.com.**